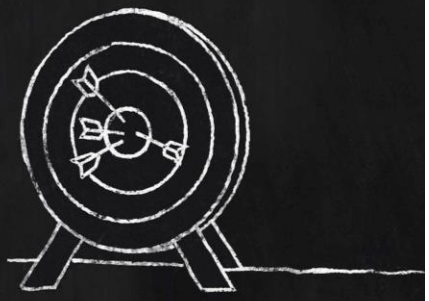
Critical Access Hospital and
Rural Health Clinic Conference

Focusing on the Quadruple Aim

Cost Reporting Pitfalls and Big Rocks



May 2, 2017

WIPFLi LLP
CPAs and Consultants
HEALTH CARE PRACTICE

AGENDA

- Rural Health Clinic Medicare Cost Report Overview
- Allowable Costs
- Non-RHC Costs
- Provider Staffing
- RHC Visits/Productivity
- Medicare Flu and Pneumonia Reimbursement
- Operational Strategies

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HEALTH CARE PRACTICE

Rural Health Clinic Medicare Cost Report Overview

Medicare Cost Report

The Medicare cost report is the method of reconciling payments made by Medicare with the allowable costs for providing services.

- *If total payments received from Medicare exceed the allowable costs, the provider must pay the difference to Medicare.*
- *If total Medicare payments are less than the allowable costs, Medicare will make an additional payment to the provider.*

Note: Medicaid cost report filing requirements vary by state.

Medicare Cost Report

**There are two types of RHCs;
cost reporting is slightly different for each:**

- Independent RHCs submit an RHC cost report to one of five regional fiscal intermediaries (transitioning to MAC).
- Provider-based RHCs submit an RHC cost report as a subset of the host provider (usually a hospital).

Medicare Cost Report

- Cost report is due five months after the close of the period covered.
- Must be filed electronically.
- Terminating cost reports are due 150 days after the termination of provider agreement.
- Extension to file the cost report may be granted by intermediary only for extraordinary circumstances such as a natural disaster, fire, or flood.

Medicare Cost Report

- What if you don't file the cost report within the 150 days?
  - Currently, there is no penalty imposed for late filing; however, Medicare will stop payments to the RHC.
  - Medicare will ask for the money paid in interim payments to be paid back.

Medicare Cost Report

Filing Consolidated Worksheets Rather Than Individual Cost Reports (Per the Medicare Claims Processing Manual, Chapter 9)

If RHCs are part of the same organization with one or more RHCs, they may elect to file consolidated worksheets rather than individual cost reports. Under this type of reporting, each RHC in the organization need not file individual cost reports. Rather, the group of RHCs may file a single report that accumulates the costs and visits for all RHCs in the organization. In order to qualify for consolidation reporting, all RHCs in the group must be owned, leased, or through any other device, controlled by one organization.

RHCs make the election to file consolidated worksheets in advance of the reporting period for which the consolidated report is to be used. Once having elected to use a consolidated cost report, the RHC may not revert to individual reporting without the prior approval of the FI.

What Is Needed to Prepare the Cost Report?

1. Financial statements
2. Cost report software
3. Provider/practitioner FTE data
4. Visits by practitioner
5. Wage and benefit summary, by position
6. Equipment (fixed asset) records
7. PS&R Report (Medicare charges and payments)
8. Influenza/pneumococcal vaccines (injection totals and invoices)

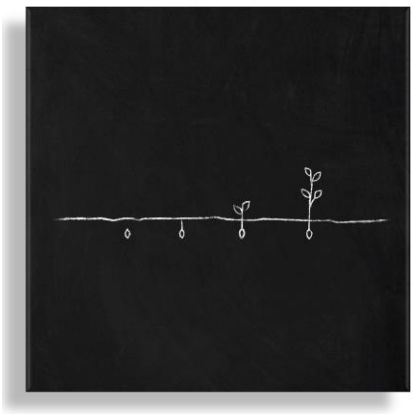
What Is Needed to Prepare the Cost Report?

9. Laboratory costs
10. Radiology/other diagnostic costs
11. Advertising costs
12. Other items:
    - Medicare bad debt log
    - Additional costs not included in financial statements
    - Costs included in financial statements not related to RHC services

Medicare Cost Report

Cost Report Components

- Trial Balance of Expenses
- Reclassification and Adjustment of Trial Balance of Expenses
  - Reclassifications
  - Adjustments
  - Related-party adjustments
- RHC Provider Statistics
- Flu/PPV Vaccine Costs
- Visits (part I), Overhead (part II)
- Determination of Medicare Reimbursement (part I) and Payment (part II)



Allowable Costs

Allowable Costs

Allowable RHC Costs:

- Defined at 42 CFR 413.
- Explained in Provider Reimbursement Manual, Pub. 15.

"Allowable costs must be reasonable and necessary and may include practitioner compensation, overhead, equipment, space, supplies, personnel, and other costs incident to the delivery of RHC services."
RHC Medicare Benefit Policy Manual

Allowable Costs

What is the source document for the "allowable RHC costs"?

- For provider-based RHCs
  - Departmental summary reports
  - Internally prepared financial statements
  - Hospital cost report data
- For independent RHCs
  - Financial statements prepared by outside accountants
  - Internally prepared financial statements
  - Tax returns?

Non-RHC Costs and Carve-Out Arrangements

Non-RHC Costs

Identify Costs of Common Non-RHC Services

- Chronic Care Management
- DME
- Hospital services (inpatient/ER/ASC)
- Laboratory services
- Medical directorships
- Mammography
- Telehealth
- Radiology services

Non-RHC Costs

Example - Laboratory Services

Most common direct costs associated with lab:

- Lab tech salaries/benefits
- Nursing salaries/benefits
- Reagent costs
- Other lab supplies
- Lab equipment depreciation
- CLIA licensure/reference lab fees

Non-RHC Costs

Carve-Out/Commingling Arrangements

- Services would be considered RHC if furnished during RHC hours and in RHC space.
- "Carve-outs" sometimes used to financially triage Medicare RHC services to Medicare Part B reimbursement (e.g., procedures).
- Carve-outs may be either space and/or time-based.

Non-RHC Costs

Carve-Out/Commingling Arrangements

According to CMS Publication 100-02, Chapter 13, Section 100:

Commingling refers to the sharing of RHC space, staff (employed or contracted), supplies, equipment, and/or other resources with an on-site Medicare Part B or Medicaid fee-for-service practice operated by the same RHC physician(s) and/or non-physician practitioner(s). Commingling is **prohibited** in order to prevent:

- Duplicate Medicare or Medicaid reimbursement (including situations where the RHC is unable to distinguish its actual costs from those that are reimbursed on a fee-for-service basis), or
- Selectively choosing a higher or lower reimbursement rate for the services.

Non-RHC Costs

Carve-Out/Commingling Arrangements

According to CMS Publication 100-02, Chapter 13, Section 100:

- RHC practitioners may not furnish RHC-covered professional services as a Part B provider in the RHC or in an area outside of the certified RHC space, such as a treatment room adjacent to the RHC, during RHC hours of operation.
- If an RHC practitioner furnishes an RHC service at the RHC during RHC hours, the service must be billed as an RHC service. The service cannot be carved out of the cost report and billed to Part B.

Non-RHC Costs

Carve-Out/Commingling Arrangements

According to CMS Publication 100-02, Chapter 13, Section 100:

- If an RHC is located in the same building with another entity such as an unaffiliated medical practice, x-ray and lab facility, dental clinic, emergency room, etc., the RHC space must be clearly defined. If the RHC leases space to another entity, all costs associated with the leased space must be carved out of the cost report.
- RHCs that share resources (e.g., waiting room, telephones, receptionist, etc.) with another entity must maintain accurate records to ensure that all costs claimed for Medicare reimbursement are only for the RHC staff, space, or other resources. Any shared staff, space, or other resources must be allocated appropriately between RHC and non-RHC usage to avoid duplicate reimbursement.

Non-RHC Costs

Carve-Out/Commingling Arrangements

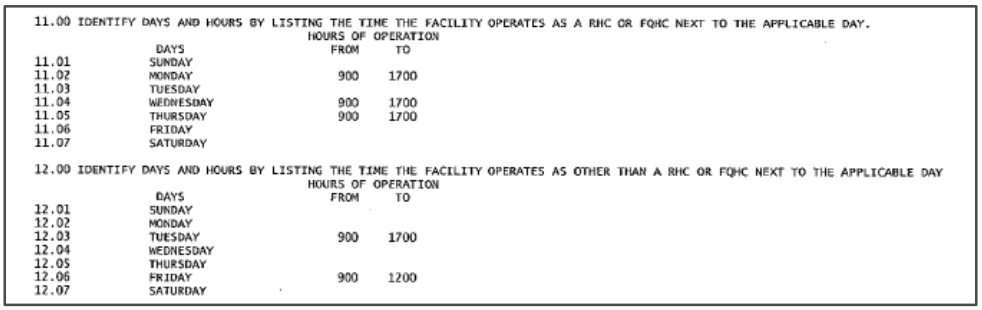
According to CMS Publication 100-02, Chapter 13, Section 100:

- This commingling policy does not prohibit a provider-based RHC from sharing its health care practitioners with the hospital emergency department in an emergency or prohibit an RHC practitioner from providing on-call services for an emergency room, as long as the RHC would continue to meet the RHC conditions for coverage even if the practitioner were absent from the facility. The RHC must be able to allocate appropriately the practitioner's salary between RHC and non-RHC time. It is expected that the sharing of the practitioner with the hospital emergency department would not be a common occurrence.

Non-RHC Costs

Carve-Out/Commingling Arrangements – Real Life Example

- Independent RHC
- Maintained RHC and non-RHC hours of operations
  - Monday, Wednesday, Thursday = RHC
  - Tuesday, Friday = non-RHC
  - Disclosed on Medicare Cost Report, Worksheet S, Part I



11.00 IDENTIFY DAYS AND HOURS BY LISTING THE TIME THE FACILITY OPERATES AS A RHC OR FQHC NEXT TO THE APPLICABLE DAY.

	DAYS	HOURS OF OPERATION FROM	TO
11.01	SUNDAY		
11.02	MONDAY	900	1700
11.03	TUESDAY		
11.04	WEDNESDAY	900	1700
11.05	THURSDAY	900	1700
11.06	FRIDAY		
11.07	SATURDAY		

12.00 IDENTIFY DAYS AND HOURS BY LISTING THE TIME THE FACILITY OPERATES AS OTHER THAN A RHC OR FQHC NEXT TO THE APPLICABLE DAY

	DAYS	HOURS OF OPERATION FROM	TO
12.01	SUNDAY		
12.02	MONDAY		
12.03	TUESDAY	900	1700
12.04	WEDNESDAY		
12.05	THURSDAY		
12.06	FRIDAY	900	1200
12.07	SATURDAY		

Non-RHC Costs

Carve-Out/Commingling Arrangements – Real Life Example

- Attempted to schedule Medicare patients requiring procedures on Tuesday and Friday only
  - Billed to Medicare Part B
- For cost reporting purposes, the RHC needed to:
  - Separate direct costs between RHC and non-RHC days
    - Including patient care staff and supplies
  - Separate visit statistics for RHC and non-RHC days
  - Separate provider FTEs for RHC and non-RHC days
  - Properly bill Medicare Part A (RHC) and Part B (non-RHC)

Non-RHC Costs

Carve-Out/Commingling Arrangements – Real Life Example

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  - Separate direct costs between RHC and non-RHC days
    - Including patient care staff and supplies
  - Separate visit statistics for RHC and non-RHC days
  - Separate provider FTEs for RHC and non-RHC days
  - Properly bill Medicare Part A (RHC) and Part B (non-RHC)

Non-RHC Costs

Carve-Out/Commingling Arrangements – Real Life Example

- **Wipfli's Solution . . .**
- Understand the reimbursement impact of eliminating the "non-RHC" days
  - Could not adequately determine the reimbursement impact.
  - Practice manager who set this up was no longer employed by the RHC.
  - Scheduling Medicare patients for certain services only on Tuesdays and Fridays was difficult and was not being done consistently.
  - Practice was not performing significant number of procedures for Medicare patients.
  - Assumed little or no impact of eliminating non-RHC days.

Non-RHC Costs

Carve-Out/Commingling Arrangements – Real Life Example

- Wipfli's Solution . . .

11.00 IDENTIFY DAYS AND HOURS BY LISTING THE TIME THE FACILITY OPERATES AS A RHC OR FQHC NEXT TO THE APPLICABLE DAY.

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	DAYS	HOURS OF OPERATION FROM	TO
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12.06	FRIDAY		
12.07	SATURDAY		

Provider Staffing

Provider Staffing

Cost Report requires separation of provider time (and cost)

- Health Care Provider FTEs:
  - *Physician*
  - *Physician Assistant*
  - *Nurse Practitioner*
  - *Visiting Nurse*
  - *Clinical Psychologist*
  - *Clinical Social Worker*

Provider Staffing

- Record provider FTE for clinic time only (this includes charting time):
  - *Time spent in the clinic*
  - *Time with SNF patients*
  - *Time with swing bed patients*
- Do not include non-clinic time in provider productivity:
  - *Hospital time (inpatient or outpatient)*
  - *Administrative time*
  - *Committee time*
- Provider time for visits by physicians under agreement who do not furnish services to patients on a regular ongoing basis in the RHC are not subject to productivity standards.

Provider Staffing

Sample Reconciliation of Provider FTE:

Clinical FTE	**0.70**
Administrative FTE	0.05
Hospital FTE	0.20
Medical Director FTE	0.05
Total FTE	**1.00**

RHC Visits/Provider Productivity

Payment Rate Calculation

This is a review (and there may be a test) . . .

$$\frac{\textit{Allowable RHC Costs}}{\textit{Rural Health Clinic Visits}} =$$

RHC Cost Per Visit (Rate)

(Not to exceed the maximum reimbursement limits.)

RHC Visits

"A RHC visit is defined as a medically-necessary medical or mental health visit, or a qualified preventive health visit. The visit must be a face-to-face (one-on-one) encounter between the patient and a physician, NP, PA, CNM, CP, or a CSW during which time one or more RHC services are rendered. A Transitional Care Management (TCM) service can also be a RHC or FQHC visit. A RHC visit can also be a visit between a home-bound patient and an RN or LPN under certain conditions."
RHC Medicare Benefit Policy Manual

RHC Visits

- Total visits, the denominator in the cost per visit calculation, should include all "visits" that take place in the RHC during hours of operation, home visits, and SNF visits for all payers.
- Total visits should not include hospital visits (either inpatient or outpatient visits) or "nurse-only" visits in the RHC setting.

NOTE: The cost-per-visit calculation considers total costs; therefore, all visits (regardless of payer type) should be included in the cost report.

RHC Visits

- Counting of "visits" is easier said than done.
- Computer-generated reports may be misleading:
  - Counting units of service instead of visits
  - Including non-visits (e.g., nurse-only 99211)
  - Including non-RHC visits (e.g., hospital visits)
  - Excluding non-billable visits (e.g., cash only; global visits)

Remember: higher visits = lower cost per visit = lower rate!

RHC Productivity

Productivity Standards:

- *Physician 4,200 visits annually for 1.0 FTE*
- *Midlevel 2,100 visits annually for 1.0 FTE*

Total visits used in calculation of the cost per visit is the greater of the actual visits or minimum allowed (FTEs x Productivity Standard).

NOTE:

The cost report productivity standards cannot be manually adjusted. Therefore, if a provider only worked a portion of a year or if the cost report only represents a portion of a year, the FTE should be adjusted accordingly.

RHC Productivity

Example 1 – Visits Equal Productivity Standards

	Positions	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4
		1	2	3	4	5
1	Physicians	6.87	25,890	4,200	28,854	
2	Physician Assistants	2.16	7,500	2,100	4,536	
3	Nurse Practitioners			2,100	-	
4	Subtotal (sum of lines 1-3)	9.03	33,390		33,390	33,390
5	Visiting Nurse					
6	Clinical Psychologist					
7	Clinical Social Worker					
8	Total FTEs and Visits (sum of lines 4-7)	9.03	33,390			33,390

RHC Productivity

Example 2 – Productivity Standards Are Greater Than Visits

	Positions	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4
		1	2	3	4	5
1	Physicians	6.87	16,221	4,200	28,854	
2	Physician Assistants	2.16	4,773	2,100	4,536	
3	Nurse Practitioners			2,100	-	
4	Subtotal (sum of lines 1-3)	9.03	20,994		33,390	33,390
5	Visiting Nurse					
6	Clinical Psychologist					
7	Clinical Social Worker					
8	Total FTEs and Visits (sum of lines 4-7)	9.03	20,994			33,390

RHC Productivity

Effect on Cost-Per-Visit

	Greater of Actual Visits or Productivity Standard Visits	Allowable Costs for Cost-Per-Visit Calculation	RHC Cost-Per-Visit
		$ 5,798,460	
Example 1	33,390		$ 173.66
Example 2	20,994		276.20

- Independent RHC – no effect; cost-per-visit limit
- Provider-based RHC to a hospital with less than 50 beds, $102.54 per visit difference
- Could affect Medicaid rate yearly or indefinitely

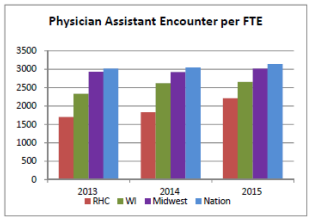
RHC Productivity

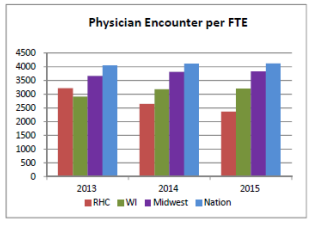
Example 2 – Benchmark Report

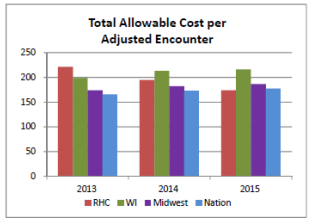
Category/Indicator	9/30/2016 RHC Values		Mean WI	Mean Midwest	Mean Nation
Number of Facilities	1		65	626	1,993
Clinic Cost per Encounter:					
Total Health Care Staff	167.68	↓	119.39	92.47	84.59
Total Direct Costs of Medical Services	181.87	↓	133.85	111.56	102.19
Allowable GME Overhead	0.00		0.00	0.00	0.00
Clinic Overhead	13.32	↑	25.08	21.72	21.20
Parent Provider Overhead Allocated	87.91	↓	106.18	71.75	67.32
Total Allowable Cost per Actual Encounter	276.20	↓	256.32	198.36	185.59
Total Allowable Cost per Adjusted Encounter	173.66	↓	216.02	186.40	177.16
Total Medicare Encounters	4,234		94,154	1,096,474	5,145,979
Average Medicare Encounters	4,234		1,449	1,752	2,582
Medicare Percent of Visits	20.17%		19.36%	18.62%	24.85%
Injection Cost:					
Cost per Pneumococcal Injection	236.66	↓	218.48	183.93	221.24
Cost per Influenza Injection	35.04	↑	80.62	55.18	73.84

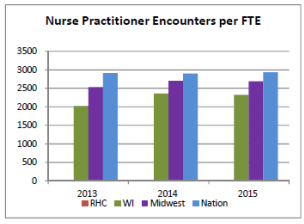
RHC Productivity

Example 2 – Benchmark Report









Flu and Pneumonia Reimbursement

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Flu and Pneumonia Reimbursement

Medicare influenza and pneumonia costs are reimbursed on the cost report:

- Cost includes staff, vaccine, and overhead costs
- These services should not be billed
- Listing of Medicare patients must be included with the cost report submission:
  - Name
  - Medicare number
  - Date of service
- Vaccine invoices are submitted with the cost report
- Pneumo/Prevnar vaccinations are reimbursable on the cost report

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Flu and Pneumonia Reimbursement

Worksheet B-1/M-4:

CALCULATION AND TOTAL OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

	Part I - Calculation of Cost	Pneumococcal	Seasonal Influenza
		1	2
1	Health Care Staff Cost	537,821	537,821
2	Ratio of Pneumococcal & Influenza Vaccine Staff Time To Total HC Staff Time	0.000651	0.006340
3	Pneumococcal & Influenza Vaccine Health Care Staff Cost	350	3,410
4	Medical Supplies Cost - Pneumococcal & Influenza Vaccine	2,981	3,648
5	Direct Cost of Pneumococcal & Influenza Vaccine	3,331	7,058
6	Total Direct Cost of the Facility	581,931	581,931
7	Total Facility Overhead	349,902	349,902
8	Ratio of Pneumococcal & Influenza Vaccine Direct Cost to Total Direct Cost	0.005724	0.012129
9	Overhead Cost - Pneumococcal & Influenza Vaccine	2,003	4,244
10	Total Pneumococcal & Influenza Vaccine Cost & Its Administration	5,334	11,302
11	Total Number of Pneumococcal & Influezna Vaccine Injections	35	341
12	Cost Per Pneumococcal & Influenza Vaccine Injection	152	33
13	# of Pneumococcal & Influenza Vaccine Injections Admins To Medicare Beneficiaries	-	169
14	Medicare Cost of Pneumococcal & Influenza & Its Administration	-	5,601
15	Total Cost of Pneumococcal & Influenza Vaccine & Its Administration		16,636
16	Total Medicare Cost of Pneumococcal & Influenza Vaccine and Its Administration		5,601

RHC Productivity

Example – Benchmark Report

Category/Indicator	6/30/2015 RHC Values	Mean CA	Mean Western	Mean Nation
Injection Cost:				
Cost per Pneumococcal Injection	8,401.75 ↓	499.26	267.71	221.24
Cost per Influenza Injection	48.56 ↑	94.83	66.03	73.84

Medicare Bad Debt

Medicare Bad Debt

- Medicare bad debt reimbursement is 65% of allowable bad debt claimed.
- Allowable deductible and coinsurance amounts only.
- Debt must be related to covered services.
  - Do not include lab, radiology, or other non-RHC services on the cost report.
- Provider must be able to establish that reasonable collection efforts were made.
  - Document that a reasonable and consistent collection effort has been made for 120 days from the date of the initial bill to the patient. (CMS is now insisting that if turned over to outside collection agency, account cannot be claimed until returned from collection agency.)

Medicare Bad Debt

CMS Pub. 15-I Section 308 states the criteria for allowable Medicare bad debt:

- Debt must be related to covered services and derived from deductible and coinsurance.
- Provider must be able to establish that reasonable collection efforts were made.
- Debt must be actually uncollectible when claimed as worthless.
- Sound business judgment must have been established to determine there was no likelihood of recovery at any time in the future.

Medicare Bad Debt

CMS Pub. 15-I Section 310 defines reasonable collection effort:

- Similar to effort for non-Medicare patients.
- Issuance of bill to responsible party.
- May include subsequent statements, collection letters, and telephone calls.
- Referral to collection agency if used for non-Medicare patients of "like amounts."

Medicare Bad Debt

Presumption of noncollectibility, CMS Pub. 15-I Section 310.2:

- If after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible.

Medicare Bad Debt

Indigent Patients, CMS Pub. 15-I Section 312:

- Clinics can claim bad debt without waiting the 120-day collection period.
- Determination of indigence must be documented in the patient's file.
- Beneficiary considered indigent if eligible for Medicaid.
- Provider must determine that no other source is legally responsible for payment.

Medicare Bad Debt

- Denials by Medicaid as secondary payer, as long as actually billed and denied, can be claimed immediately.
- Documented charity care write-offs can be claimed immediately.
- Provider Reimbursement Manual – Part I Chapter 3
- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.html

Medicare Bad Debt

Documentation Required With Cost Report:

- Beneficiary name and HIC number
- Date(s) of service
- Date of first bill sent to patient
- Medicare paid date (R/A)
- Write-off date
- Separation of deductible and coinsurance amounts
- Medicaid payment and paid date (if any)

Reimbursement Settlement

Exhibit 2
Listing of Medicare Bad Debts and Appropriate Supporting Data

Provider ____________ Prepared By ____________
Prov. Number____________ Date Prepared ____________
FYE ____________ Inpatient ____________ Outpatient ____________
SNF ____________ RHC____________

(1) Patient Name	(2) HIC NO.	(3) Dates of Service From	To	(4) Indigency & Wel. Recip (ck if apply) Yes	Medicaid #	(5) Date First Bill Sent To Beneficiary	(6) Date Collection Efforts Ceased	(7) Medicare Remittance Advice Date	(8) Deduct	(9) Co-Ins	(10) Total
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Operational Strategies

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Reimbursement Settlement

The Provider Statistical and Reimbursement System (PS&R) is an essential component of cost report reconciliation

- Report summarizes all paid Medicare claims
  - Visits
  - Charges (including preventive)
  - Deductible
  - Medicare payments

Reimbursement Settlement

Reimbursable Cost

- Program visits (per PS&R) times rate per encounter equals program costs.
- Medicare pays 80% of cost less deductibles to allow for coinsurance.
- Preventive services and vaccines are excluded from coinsurance calculation.
- Settlement equals Medicare's share of cost (including Medicare influenza and pneumonia costs) less interim payments received, plus Medicare bad debts claimed (reimbursed at 65%).

Reimbursement Settlement

PS&R Redesign System:

- Allows/requires users to download summary PS&R reports via the Internet.
- All users must first establish an account on the CMS Enterprise Identity Management (EIDM) website. https://portal.cms.gov/wps/portal/unauthportal/home/

Reimbursement Settlement

Program ID: REDESIGN
Paid Dates: 08/01/07 THRU 02/02/17
Report Run Date: 02/02/17
Provider FYE: 09/30
Provider Number:

PROVIDER SUMMARY REPORT
CLINIC - RURAL HEALTH

Page: 1
Report #: OD44203
Report Type: 710

	SERVICES FOR PERIOD 10/01/14 - 09/30/15	SERVICES FOR PERIOD 10/01/15 - 09/30/16	SERVICES FOR PERIOD 10/01/16 - 09/30/17	SERVICES FOR PERIOD 10/01/17 - 09/30/18
STATISTIC SECTION				
CLAIMS	2,102	2,259	553	0

CHARGE SECTION

REV CODE	DESCRIPTION	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES
0300	LABORATORY or (LAB)	0	$0.00	0	$0.00	0	$0.00	0	$0.00
0305	LAB/HEMATOLOGY	0	$0.00	0	$0.00	0	$0.00	0	$0.00
0412	INHALATION SVC	0	$0.00	0	$0.00	0	$0.00	0	$0.00
0439	OTHER OCCUP THER/15 MIN	0	$0.00	0	$0.00	0	$0.00	0	$0.00
0460	PULMONARY FUNC	0	$0.00	0	$0.00	0	$0.00	0	$0.00
0510	CLINIC	0	$0.00	0	$0.00	0	$0.00	0	$0.00
0521	RURAL/CLINIC	1,744	$316,302.25	1,910	$343,941.00	455	$96,762.00	0	$0.00
0522	RURAL/HOME	2	$621.00	1	$197.00	0	$0.00	0	$0.00
0524	RHC/FQHC PT A SNF	28	$9,644.00	26	$9,543.00	10	$3,674.00	0	$0.00
0525	RHC/FQHC SNF	328	$50,517.00	322	$53,835.00	90	$15,554.00	0	$0.00
0636	DRUGS/DETAIL CODE	0	$0.00	0	$0.00	0	$0.00	0	$0.00
0730	EKG/ECG	0	$0.00	0	$0.00	0	$0.00	0	$0.00
	TOTAL COVERED CHARGES	2,102	$377,084.25	2,259	$407,516.00	555	$115,990.00	0	$0.00

REIMBURSEMENT SECTION				
GROSS REIMBURSEMENT	$207,942.65	$225,030.00	$58,409.17	$0.00
LESS				
CASH DEDUCTIBLE	$32,003.69	$35,863.66	$9,509.39	$0.00
BLOOD DEDUCTIBLE	$0.00	$0.00	$0.00	$0.00
COINSURANCE	$69,016.10	$74,330.47	$21,296.14	$0.00
SEQUESTRATION	$2,394.13	$2,593.13	$645.33	$0.00
REBILLING ADJUSTMENT	$0.00	$0.00	$0.00	$0.00
NET REIMBURSEMENT	$104,528.73	$112,242.74	$26,958.31	$0.00

Reimbursement Settlement

PROVIDER STATISTICAL AND REIMBURSEMENT SYSTEM

Program ID: REDESIGN
Paid Dates: 08/01/07 THRU 02/02/17
Report Run Date: 02/02/17
Provider FYE: 09/30
Provider Number:

PROVIDER SUMMARY REPORT
CLINIC - RURAL HEALTH - PREVENTIVE SERVICES

Page: 1
Report #: OD44203
Report Type: 715

	SERVICES FOR PERIOD 10/01/14 - 09/30/15	SERVICES FOR PERIOD 10/01/15 - 09/30/16	SERVICES FOR PERIOD 10/01/16 - 09/30/17	SERVICES FOR PERIOD 10/01/17 - 09/30/18
STATISTIC SECTION				
CLAIMS	65	333	144	0

CHARGE SECTION

REV CODE DESCRIPTION	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES	UNITS	CHARGES
0521 RURAL/CLINIC	35	$17,064.00	330	$86,294.00	135	$43,580.00	0	$0.00
TOTAL COVERED CHARGES	35	$17,064.00	330	$86,294.00	135	$43,580.00	0	$0.00

REIMBURSEMENT SECTION

GROSS REIMBURSEMENT	$2,811.56	$26,766.08	$10,992.90	$0.00
LESS				
CASH DEDUCTIBLE	$0.00	$0.00	$0.00	$0.00
BLOOD DEDUCTIBLE	$0.00	$0.00	$0.00	$0.00
COINSURANCE	$0.00	$0.00	$0.00	$0.00
NET MSP PAYMENTS	$0.00	$0.00	$0.00	$0.00
PIONEER REDUCTION	$0.00	$0.00	$0.00	$0.00
SEQUESTRATION	$56.29	$536.32	$220.35	$0.00
REBILLING ADJUSTMENT	$0.00	$0.00	$0.00	$0.00
NET REIMBURSEMENT	$2,755.27	$26,229.76	$10,772.55	$0.00

Operational Costs

Related Parties:

Related through ownership or control (board of directors, key employees)

"The intent is to treat the costs incurred by the supplier as if they were incurred by the provider itself."
CMS Pub. 15-1 (PRM)

Operational Costs

Related Parties:

- Building and equipment leases
- Contracted employees
- Purchased services (e.g., cleaning, billing, etc.)

  Examples:

  - Clinic shareholders own clinic building through separate real estate partnership. Lease to RHC.
  - Clinic management forms separate billing service and contracts with RHC.

Operational Costs

Related-Party Example – Building Lease:

- RHC pays $4,000 per month ($48,000 per year) to owners' partnership for building rent.
- Actual annual cost of building incurred by partnership:
  - Interest on mortgage = $20,000
  - Depreciation on building = $8,000
  - Property taxes = $6,000
  - Insurance on building = $1,000
  - Total annual costs = $35,000
- RHC costs must be reduced by $13,000.

Operational Costs

Related-Party Example – Building Lease:

Worksheet A-2-1

Part II Costs incurred and adjustments required (as result of transactions with related organizations):

	Line No	Cost Center	Expenses Items	Amount	Amount Allowable in Cost	Net Adjustments (Col 4 minus Col 5)
	1	2	3	4	5	6
1	26	RENT	RENT	48,000	-	48,000
2	26	RENT	INTEREST	-	20,000	(20,000)
3	30	DEPRECIATION-BUILDINGS AND FIXTURES	DEPRECIATION	-	8,000	(8,000)
4	33	PROPERTY TAX	PROPERTY TAXES	-	6,000	(6,000)
4.01	27	INSURANCE	BUILDING INSURANCE	-	1,000	(1,000)
5	Totals			48,000	35,000	13,000

Helpful Hints

- Collect as much data as possible on an ongoing basis.
- Set up accounting procedures to collect as much financial data in the form and level of detail required for year-end reporting. Use the cost report forms for reference.
- Determine early whether the clinic will need to collect special data for the cost report (i.e., related-party expense).
- Be consistent from year to year.
- Use the PS&R report provided by the intermediary to report Medicare visits, deductibles, and payments.

Helpful Hints

- Send adequate documentation to support information on the cost report.
  - Injection logs
  - Bad debt logs
  - Working trial balance
  - CMS 339 questionnaire
  - Workpapers to explain reclasses on W/S A-1 and adjustments on W/S A-2
- Review the cost report for reasonableness (i.e., $700 cost per pneumococcal injection is not reasonable).

Helpful Hints

Cost Report Worksheets:	Independent	Provider-based
RHC Basic Information (address, provider number, certification date)	S	S-2/S-8
Expense Information	A	A/M-1
Reclassifications	A-1	A-6
Adjustments	A-2	A-8
Related-Party Adjustments	A-2-1	A-8-1
Allocation of Overhead (Hospital)	-	B Part I
Visits and FTEs; Allocation of Overhead to RHC/Non-RHC	B, Part I	M-2
Influenza and Pneumonia Cost	B-1	M-4
Cost-Per-Visit, Medicare Bad Debt, Settlement	C	M-3
Medicare Payments Entry	-	M-5

Questions?

Thank you!

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